FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN6702	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OVERTON COUNTY NURSING HOME	318 BILBREY STREET LIVINGSTON, TN 38570

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments During the annual Licensure survey conducted on April 9 - 11, 2012, at Overton County Nursing Home, complaints #TN00029104 and #TN00029445 were investigated. No deficiencies were cited for complaint #TN00029445 under 1200 - 8 - 6, Standards for Nursing Homes.	N 000		
N1129	1200-8-6-.11(2)(a)9.(xx) Records and Reports (2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence of accident that results in death, life threatening or serious injury to a patient. (a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to: 9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include: (xx) patient abuse, patient neglect, or misappropriation of resident/patient funds; This Rule is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to report an injury of unknown origin for one (#8) of twenty-nine residents sampled.	N1129	Unusual events shall Be reported to the Department Of Health within seven business days of the date of the identification of the abuse of a patient or an unexpected occurrence of accident that results in death, life threatening or serious injury to a patient. The DON is responsible for reporting unusual incidents for the facility. If an event occurs and the determination is that a resident is abused, or an event occurs that results in death, life threatening or serious injury to a patient the incident will be reported to the Department of Health within the time allotment.	4/11/2012

Division of Health Care Facilities

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4-25-12

STATE FORM 6899 4WM011 If continuation sheet 1 of 3

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N1129	Continued From page 1 The findings included: Medical record review revealed resident #8 was admitted to the facility on December 21, 2004, and readmitted on October 14, 2011, with diagnoses to include Cerebrovascular Accident, Dementia, Osteoarthritis, Osteoporosis, Transient Ischemic Attack, and Diverticulosis. Review of the Minimum Data Set dated February 23, 2012, revealed the resident was severely impaired cognitively; was total dependence for transfers, bathing, dressing, and grooming; was incontinent of bowel and bladder; received tube feeding at 25 ml (milliliters) an hour; and was transferred to the chair daily. Review of nursing notes dated December 27, 2011, revealed "...dark purple bruising and swelling from lt. (left) hand middle finger spreading to top of left hand, 5 cm (centimeter) x 4 cm...". Review of radiology report of the left hand dated December 27, 2011, revealed "...bony structure is uniformly mineralized and osteoporotic. There is a nondisplaced fracture at the proximal aspect pf the proximal phalynx of the third finger...". Review of the facility investigation revealed an unknown cause of the injury. During interview on April 11, 2012, at 1:00 p.m., in the conference room, the Director of Nursing confirmed the investigation was completed but the facility failed to report it via the Unusual Incident Reporting System as a case of possible resident abuse. COMPLAINT #29104	N1129	The DON will meet with The facility Administrator concerning all unusal incidents within a timely manner and an investigation will follow. Upon conclusion of the incident the facility will notify the Department of Health concerning issues that are determined fall under the Tennessee Department of Health guidelines for reporting an unusual incident. The DON and the QA committee will cover any incidents which are reportable to state on a quarterly basis to determine compliance.	

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